Heartchangers
Partners in ministry making a difference

Christian Medical & Dental Associations
Changing Hearts in Healthcare

1

Name

E-mail address | Home Phone | Office Phone

Address

City | State | Zip Code

Your gift will be used to support the CMDA annual fund unless you specify an area of ministry you would like to advance (i.e., name of Regional Ministry, Area Ministry, GHO, Changing Hearts Campaign, etc).

2

Specific Ministry _____

I/we plan to fulfill this gift by giving: ☐ One time gift ☐ Monthly ☐ Quarterly ☐ Annually

I/we plan to give $_____ over, ☐ 1 yr ☐ 2 yrs ☐ 3 yrs

Beginning Date (mo/yr): _____

Amount Enclosed $_____ or, ☐ Charge my: ☐ MasterCard ☐ VISA ☐ American Express

Card Number | Expiration Date

Name as it appears on credit card (please print)

Signature _____

3

Draft Options: **Start Date** _____ **Ending Date** _____

☐ **Credit Card** (listed above)

Draft Dates: ☐ 8th or ☐ 23rd

☐ **Bank Draft** **Account Type** ☐ Checking (enclose a voided check) ☐ Savings

or

Bank Name

Bank Address

Routing Number | Account Number

Draft Dates: ☐ 1st or ☐ 18th

4

I hereby authorize the Christian Medical and Dental Associations (CMDA) to initiate an automatic electronic payment from my credit card, checking or savings (financial institution named above) account as indicated above and I authorize my credit card company or my Bank to honor this withdrawal, effective immediately. I understand that this authority is to remain in effect until cancelled in writing either by me, CMDA, or the Bank.

Signature_____

5

Mail or Fax:

CMDA
P.O. Box 7500
Bristol, TN 37621-7500

Fax
423.844.1005

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Christian Medical & Dental Associations retains complete control and administration over the use of all donated funds including designated gifts.